IN THE

Supreme Court of the United States

OCTOBER TERM, 1964

No. 111

DEPARTMENT OF MENTAL HYGIENE OF THE STATE OF CALIFORNIA, *Petitioner*,

v.

EVELYN KIRCHNER, Administratrix of the Estate of ELLINOR GREEN VANCE, *Respondent*.

On Writ of Certiorari to the Supreme Court of the State of California

Brief for the National Association for Retarded Children, Inc., and the American Orthopsychiatric Association Amicus Curiae

A. KENNETH PYE
JOHN R. SCHMERTZ, JR.
506 E Street, N. W.
Washington, D. C. 20001

BERNARD D. FISCHMAN
330 Madison Avenue
New York, New York 10017

PRESS OF BYRON S. ADAMS, WASHINGTON, D. C.

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INTEREST OF THE AMICUS

The National Association for Retarded Children, Inc., is a voluntary organization which is represented in every state by local and state member units. The Association is dedicated to promote the welfare of

mentally retarded persons of all ages. Among its specific objectives is the advancement of treatment, services and facilities for mental retardates and the development of broader public understanding of the problems of mental retardation.

The American Orthopsychiatric Association, with over 2,000 members, is one of the leading organizations in the United States concerned with problems of mental disorder and abnormal behavior. The Association seeks to coordinate and integrate the activities of specialists in medicine, psychiatry, clinical psychology, psychiatric social work, and other behavioral scientists who are concerned with normal and abnormal behavior.

The validity of state statutory provisions requiring citizens to pay part of the costs of relatives institutionalized by reason of mental deficiency or mental illness is of grave concern to each of these organizations.

QUESTION PRESENTED

Whether state action imposing financial liability upon a citizen for the costs of institutionalizing a mentally ill or mentally retarded relative violates the Fourteenth Amendment.

SUMMARY OF ARGUMENT

State action which imposes financial liability upon a citizen for the institutionalization of a mentally ill or mentally retarded relative violates the Equal Protection Clause of the Fourteenth Amendment.

The conceded purpose of statutes such as the California statute now before the Court is to raise revenue. The financial liability is imposed on the basis of a blood

relationship. The existence or non-existence of familial ties bears no relationship to whether one citizen has the ability to pay or should be required to contribute more than his fellow citizens for the maintenance of the public institutions of the state. The imposition of an unequal financial burden solely on the basis of family membership places an unjust economic burden on a few and may aggravate existing emotional strain upon the family and deprive well members of the family of economic and educational opportunities which could be enjoyed in the absence of the oppressive state action.

The invidious nature of the discrimination is made clearer by the recognition that the same financial burden is not placed on the families of persons suffering from different afflictions. In California the family, one of whose members is mentally deficient, can look to the state for hospitalization without the acceptance of substantial financial liability, while the family, one of whose members is mentally ill, may look forward to substantial payments for an indefinite period of time. In other states families of both the mentally retarded and the mentally ill are charged for care while families of the blind, deaf, the crippled, and the aged are exempted. Certainly nothing intrinsic to the conditions of mental illness or mental retardation justifies such discrimination.

The argument of unequal protection is buttressed by the absence of standards for assessment, the wide differentials in charges imposed, and the failure to relate charges to the services provided. In short, the California statutory scheme is a sophisticated device to segregate the families of the mentally ill and to impose a special tax against them for the purpose of subsidiz-

ing the operation of state facilities with no other justification than the existence of the family relationship.

The deep importance of the family unit and its significance in American society is recognized. However, the legislative classification on the basis of family bears no relationship to the admitted statutory purpose of raising revenue. The existence or non-existence of a moral obligation on the part of one member of a family to assist another member is not in issue. The issue is whether a state may impose financial liability on the families of the mentally ill on the asserted basis of such an obligation for the purpose of raising revenue. Amicus submits that nothing in the family relationship justifies such overt discrimination against families of the afflicted.

ARGUMENT

I. THE DIMENSIONS OF THE PROBLEMS OF MENTAL RETARDATION AND MENTAL ILLNESS

A. The Incidence of Mental Retardation and Mental Illness.

The resolution of the issues of the case require an understanding of the dimensions of the problems of mental illness and mental retardation in America.

Mental retardation and mental illness unquestionably pose serious problems of health and social and economic well-being which the nation must face in the latter part of the twentieth century.

According to the President's Panel on Mental Retardation[1] the mentally retarded are children and

[1] PRESIDENT'S PANEL ON MENTAL RETARDATION, A PROPOSED PROGRAM FOR NATIONAL ACTION TO COMBAT MENTAL RETARDATION 1-5 (1962). The following three paragraphs of text are derived from the aforementioned source.

adults who, because of inadequately developed intelligence, are significantly impaired in their ability to learn and to adapt to the demands of society. It is estimated that about 3 per cent of the population of the United States (or 6 million children and adults) are to be classified as mentally retarded. Some of the retardation is severe; most cases are relatively mild. About 126,000 babies born each year will be regarded as mentally retarded at some time in their lives. Mental retardation afflicts twice as many individuals as blindness, polio, cerebral palsy and rheumatic heart disease, combined. Only four significant disabling conditions—mental illness, cardiac disease, arthritis and cancer—have a higher prevalence. These afflictions tend to occur late in life while retardation comes early. About 400,000 adults and children are so retarded that they need constant care or supervision or are severely limited in their ability to care for themselves and to take part in productive work. The other 5 million suffer from milder disabilities. Over 200,000 adults and children, mostly from the severe and profound mentally retarded groups are cared for in residential institutions. From 15 to 20 million persons are members of families in which there is a mentally retarded individual.

Mental retardation does not respect station in life, income or geographic location. Nevertheless, there are striking variations in incidence within socio-economic groups and geography. A total of 716,000 persons or 4 per cent of those examined for the draft during World War II were rejected on the basis of "mental deficiency." Regional rejection rates ranged from 1 per cent in the Far West to nearly 10 per cent in the Southeast. Moreover, draft rejection rates for mental deficiency

were six times as high for nonwhites as for whites. Prevalence of mental retardation tends to be associated heavily with conditions leading to lack of prenatal care, prematurity of birth and high infant death rates.

Mental illness also rates as one of this nation's most serious problems. According to figures found in a 1958 report of the Joint Committee on Mental Illness and Health,[2] more than half of all hospital beds in this country are occupied by the mentally ill. At least 6 per cent of the total population is estimated to suffer from a serious mental disorder.[3] Out of the 980,000 disability discharges from the Army during the period December 1941 through December 1945, 43 per cent were for neuropsychiatric reasons.[4] Not only are there a large number of persons requiring treatment for mental illness, but the estimated duration of the needed treatment is substantial. Out of 500,000 resident patients in state mental hospitals, an average of one-fourth have been hospitalized for more than 16 years, one-half for more than 8 years, and three-fourths for more than 2.5 years.[5] The direct and indirect annual costs to the American economy resulting from mental illness has been estimated at a minimum of 2.4 billion dollars.[6]

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[2] FEIN, ECONOMICS OF MENTAL ILLNESS AND HEALTH (Report to Joint Commission on Mental Illness and Health, Monograph Series No. 2) (1958) 4.

[3] *Ibid.*

[4] *Ibid.*

[5] *Ibid.*

[6] *Id.* at 132.

B. State Action to Meet the Problems of Mental Illness and Mental Retardation.

Maintenance expenditures in public mental hospitals increased from about $618,000,000 in 1955 to over one billion dollars in 1962. At the end of 1962, there were 515,948 resident patients.[7]

Maintenance expenditures for public institutions for the mentally retarded amounted to almost $326,000,000 in 1962, an increase of over 200 per cent since the period 1953-55 while the number of resident patients for the same period of time increased 24.4 per cent to a 1962 figure of 173,699.[8] State and county general mental institutions in 1963 had an average daily resident population of 511,708. These institutions spent a total of $1,084,713,981 on maintenance, resulting in an annual expenditure per resident patient of $2,119.79.[9] Average annual expenditures for individual states per resident patient range from a low of $1,037.95 in Mississippi to a high figure of $6,953.94 for Alaska, while California stands somewhat above the national average with a figure of $2,818.75.[10] With respect to the mentally retarded, public mental institutions spent a national average of $1,858.51 per resident patient during 1962. Individual annual state expenditures per resident patient range from a low of $657.79 for Mississippi to a high of $3,442.75 for Kansas, while California spends $2,910.95.[11] Thus it is clear that

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[7] U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE MENTAL HEALTH STATISTICS CURRENT REPORTS, SERIES MHB-H-7, Jan., 1963 at 5.

[8] *Id.* SERIES MHB-I-7, April, 1963, at 5.

[9] *Id.* SERIES MHB-H-8, Jan., 1964, at 8.

[10] *Ibid.*

[11] *Id.* SERIES MHB-I-7, April, 1963, at 11.

most states have recognized the growing problems of mental illness and retardation and have appropriated large sums in an effort to alleviate them.

C. Conditions in State Mental Institutions.

The problems of the states in caring for the mentally retarded was emphasized in President Kennedy's message to the 88th Congress on February 5, 1963 when he pointed out:

> State institutions for the mentally retarded are badly under-financed, under-staffed and overcrowded. The standard of care is, in most instances so grossly deficient as to shock the conscience of all who see them.[12]

Moreover, almost 20 per cent of the 278 state mental institutions are fire and health hazards by the standards of their own state laws and regulations. This percentage will constantly increase since more than one-half of these institutions were opened before the beginning of the century.[13] Despite efforts to the contrary, only a small percentage of state institutions can be said to be therapeutic and not merely custodial. In 1959, for example, the ratio of psychiatrists to patients in these institutions was 1 to 500 while according to the standards of the American Psychiatric Association, the state mental institutions are only 20 per cent adequately staffed with nurses, 35 per cent with social workers, 65 per cent with psychologists, and 45 per cent with psychiatrists.[14] Moreover, the average expenditure

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[12] U.S. DEP'T OF HEALTH, EDUCATION AND WELFARE REPORT TO THE PRESIDENT: IMPLEMENTATION OF MENTAL RETARDATION PROGRAMS, (1964) at 80.

[13] H.R. REP. No. 694, 88th Cong., 1st Sess. (1963) U.S. CODE CONG. & AD. NEWS, at 1064.

[14] *Ibid.*

per patient day in state mental institutions is about $4.50 as compared with $12 in the Veterans' Administration psychiatric hospitals and about $32 per day in community general hospitals.[15] This low standard of care affects the duration of time that a patient must spend in the state institution. Thus, the average stay of patients suffering from schizophrenia, the most common of the severe mental disturbances, is nearly 11 years, despite the fact that it is possible to rehabilitate as many as 4 out of 5 such patients in a much shorter period of time.[16]

Similar overcrowded, understaffed, and obsolete conditions exist for the mentally retarded in state institutions. As of 1960, about 160,000 of the mentally retarded were in 108 residential public institutions specifically designated for their care. Another 10,000 were in private institutions and the remaining 43,000 cared for in public hospitals for the mentally ill. On the average, each institution was caring for 350 patients in excess of stated capacity and had a waiting list of more than 300.[17]

D. Limited Federal Assistance to the States.

In recognition of the magnitude and importance of mental health as a national problem, the Federal Government has authorized substantial sums to bolster state action.

However, the major thrust of Federal effort is addressed to non-institutional programs. Moreover, persons otherwise eligible for old-age assistance, perma-

[15] *Ibid.*

[16] *Ibid.*

[17] *Id.* at 1062.

nent and total disability assistance and other categorical aid programs of whose cost the Federal Government bears a substantial fraction become ineligible for such assistance when hospitalized in public mental institutions. The extent of the contribution of the Federal Government to support outside of institutions may be gauged by the fact that in the category of aid to permanently and totally disabled alone, about 80,000 retarded adults will receive payments during the fiscal year 1965 at a cost of over $40,000,000.[18] The Federal Government also makes no formula grants to sustain the services of public mental institutions and its incidental contributions to direct services through special project grants amount to less than 2% of the total cost of operating these institutions.[19] Thus, in contrast to other health and welfare programs the burden of long-term in-hospital care falls almost entirely on the states or counties, the patients and their relatives.

Both the Bureau of Family Services programs of the Department of Health, Education and Welfare and the Social Security Administration are deeply committed to financial assistance for income maintenance of the mentally retarded. Thus, in the category of aid to the permanently and totally disabled, about 80,000 retarded adults will receive payments during fiscal year 1965 at a cost of over $40,000,000.[20]

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[18] U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE REPORT TO THE PRESIDENT: IMPLEMENTATION OF MENTAL RETARDATION PROGRAMS (1964), at 92.

[19] The major contribution is the recently inaugurated $6,000,000 Hospital Improvement Program.

[20] U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE MENTAL RETARDATION, FISCAL YEAR 1965 PROGRAM OF THE U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE (1964), at 28.

E. Methods and Extent of State Collections From Private Persons.

1. Varying techniques employed by states in assessing liability.

The several states differ considerably in the manner by which they attempt to assess financial liability against private persons. One of the chief areas of difference is in the classification of which persons shall be liable. The extent of the variations precludes exhaustive treatment. However, certain patterns are clear. As a rule, liability for at least part of the cost of care in state mental institutions is imposed on the patient or members of his family.[21] Five states, Arizona, New Mexico, South Carolina, South Dakota and Georgia limit statutory liability to the estate of the patient. Each of the 45 remaining states places some type of liability upon other members of the patient's family.[22] In some states for example, California, Nevada, Michigan, New York and Oregon,[23] the liability imposed may be joint and several. In other states, differing priorities for liability purposes have been established.[24] The most common classification limits liability to spouses, parents and children. At least nine states, however, impose a support liability upon more remote relations such as grandparents, grandchildren, brothers and sisters.[25]

Another substantial variation among the states is in the range of expenses for which liability is created.

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[21] Mernitz, *Private Responsibility for the Costs of Care in Public Mental Institutions*, 36 IND. L. J. 443, 450 (1961).

[22] *Id.* at p. 451.

[23] *Id.* at p. 451, n.27.

[24] *Id.* at p. 451, n.28.

[25] *Id.* at p. 451.

Among the states which require payments from parents of the mentally retarded, for example, there is a total lack of uniformity. It has been stated as of 1960:

> Of these 40 states, 4 charge for minors only, and Iowa charges only for patients between the ages of 21 and 50 years, leaving 35 states which can collect amounts, adjusted from maximum legal charges varying from $20-$180 per month, for as long as the mentally retarded patient may live or the finances of the parents (living or dead) can provide. In 8 states (Delaware, Kansas, Nevada, New Hampshire, New York, Ohio, Oregon, Pennsylvania) even the difference between the adjusted monthly charge and the maximum legal charge accrues as a debt to the state.[26]

Many but not all states base their statutory charges on the per capita costs of the institutional program of the state. A study made by the National Association for Retarded Children in 1963 shows that the number of these states increased from 20 in 1956, to 28 in 1960-61.[27] In answer to a questionnaire seeking information as to the items that each state includes in its per capita cost figure, 28 states responded as follows: 28 include food, lodging, medical care and staff salaries; 27 include formal education programs; 26 include costs of rehabilitation; 24 include staff training and building repair and maintenance; 1 state includes

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[26] Eagle, *Charges for Care and Maintenance in State Institutions for the Mentally Retarded*, 65 AMERICAN JOURNAL OF MEDICAL DEFICIENCY (1960) quoted in Legislative Research Bureau, *Reimbursement for Care of Mental Patients: A Compilation of State Programs and Policies*, Mass. H. Rep. No. 3380 (Feb. 19, 1962), at 11.

[27] THE COMMITTEE ON RESIDENTIAL CARE OF THE NATIONAL ASSOCIATION FOR RETARDED CHILDREN, CHARGES FOR RESIDENTIAL CARE OF THE MENTALLY RETARDED (1963) at 9 and Fig. 8 of Appendix.

capital outlay for building construction.[28] Other items taken into account in computing per capita cost in most states are police and fire protection, and research. Many states include even the cost of clothing for indigent residents in the charges made on a per capita cost basis.[29]

In this connection, it is important to note that states makes no allowance for the value of the work performed by some patients within the institution in computing the cost for which a claim is made upon relatives or upon the estate of those patients. Work performed by patients is substantial and has an important effect on institutional operating costs. Failure to take this into account is a further source of inequity. Cf. *In re Stobie's Estate*, 30 Cal. App. 2d 525, 528, 86 P. 2d 883, 886 (1939)

There is also a great deal of variation among the states as to the maximum daily fees chargeable against both the mentally retarded and the mentally ill. The following chart[30] shows the groups of states matched with the maximum daily charges:

Maximum Daily Charges	For Mentally Ill	For Mentally Retarded
No charge	0 states	3 states
Up to $3.00	12 states	20 states
$3.01 to $4.00	5 states	8 states
$4.01 to $5.00	13 states	11 states
$5.01 to $6.00	10 states	5 states
$6.01 to $7.00	2 states	3 states
Over $7.00	8 states	0 states

[28] *Ibid.*

[29] *Id.* at 10.

[30] *Legislative Research Bureau, Reimbursement for the Care of Mental Patients: A Compilation of State Programs and Policies,* MASS. H. REP. No. 3380, at 13 (Feb. 19, 1962).

A recent study points out that in spite of high and steadily rising charges in many states that make a pretense of attempting to recover the cost of care, only a very small portion of the institution budget is actually recovered in charges.[31] The greatest share collected in any state is about 12 per cent, and two-thirds of the states reporting collected less than 8 per cent.[32]

The burden of payment also falls unequally on private persons among the several states. Only a small percentage pays the full charge—in some states no one pays in full, and in no state do more than 10 per cent pay this amount.[33] The percentage of residents who pay part of the statutory charge varies from 5 per cent to 60 per cent, depending upon the state; a high percentage, between 25 and 96 per cent, pay nothing.[34] At least part of the explanation for the above fluctuations has been attributed to the range of income distribution for American families. Thus, for 1960, U. S. Internal Revenue Service figures show that about one out of three American families earns less than $4,000 per year (about $11.00 per day) and that more than one out of every two families earns $6,000 or less (about $16.70 per day).[35]

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[31] THE COMMITTEE ON RESIDENTIAL CARE OF THE NATIONAL ASSOCIATION FOR RETARDED CHILDREN, CHARGES FOR RESIDENTIAL CARE OF THE MENTALLY RETARDED 12 (1963).

[32] *Ibid.*

[33] *Ibid.*

[34] *Ibid.*

[35] *Id.* at 12 and Fig. 4, Appendix. See Chart of Maximum Charges, *supra*, which indicates that 33 states can charge over $4.00 per day for the mentally ill and 19 can charge above this amount for the retarded.

It also is possible that a relative who, during his lifetime, was not required to pay the full statutory charge might have the accrued unpaid charges assessed against his estate, thus depriving the next generation of the benefit of these resources.[36] As one commentator has stated:

> Depriving a dependent of an inheritance may shift his dependency to the state, costing the state more in the long run than any amount it may realize by pressing collection.[37]

Besides California, the statutes of Colorado, Iowa, Maryland, Minnesota, Nevada, New York, Oregon and Vermont provide that the difference between the adjusted rate or charge and the maximum charge shall accrue as a debt collectible from the estate of the patient and, in some cases, from the estate of any liable relative.[38]

Although there are many variations in the effect of collection programs in the states, there is one trend which is clear. Available data from 39 states as to amounts collected from mentally ill patients indicates that collections from them or their relatives in 30 states increased by more than 10 percent in 1959, and,

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[36] *Cf. Department of Mental Hygiene v. Shane*, 142 Cal. App. 2d 881, 299 P. 2d 747, 749 (1956) where the Court stated: "The Code does not mention the size of the deceased's estate as having any bearing on the right to recover. It might be that during his lifetime a man would not be able to pay for hospitalization of an incompetent son or the father by good fortune might accumulate a substantial estate late in life. Irrespective of that, whatever estate he does have is liable. . . ."

[37] Mernitz, *Private Responsibility for the Costs of Care in Public Mental Institutions*, 36 IND. L.J. 443, 456 (1961).

[38] *Id.* at 456, n. 44.

of these states, 11 showed an increase of more than 20 per cent.[39] With respect to collections for the mentally retarded, there was an increase of more than 10 per cent in 21 out of 33 states reporting between 1958 and 1959 and, as to 12 of these 21, an increase of more than 20 per cent.[40]

2. Lack of statutory standards for administrative determination of ability to pay.

It is clear that in no state is the maximum legal liability of a patient or his relative actually enforced. Apart from the usual cases where the money claims cannot be processed or collected, the explanation seems to lie in the attempts by the states to vary the actual charges collected based on "ability to pay." Thus, Section 6651 of California's Welfare and Institutions Code sets the liability under the law as the statewide average per capita cost of maintaining mentally ill patients in all state hospitals as determined by the Director of Mental Hygiene. Upon satisfactory proof of inability to pay by the person liable, the Director may reduce, cancel or remit the amount to be paid. A search of these statutes, however, fails to indicate the elements of such "satisfactory proof" or any guidelines for the administrative decision of who is able to pay and who is not.

The lack of recognized standards for determining ability to pay leads to a great disparity in the amounts exacted throughout the nation. A recent study collected information from the various state agencies as to the amount that would be assessed for one patient

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[39] Legislative Research Bureau, *Reimbursement for the Care of Mental Patients supra* note 26 at 14.

[40] *Id.* at 14-15.

against a sample family of three with no unusual debts or assets and with a gross income of $6,000 per year.[41] Nine states stated for such a family there would be "no charge," eight states stated that they could specify "no set charge," 12 states gave a firm amount or range of amounts from $300 to $980 per year and 11 states gave amounts which the charge would be "less than" ranging from about $100 to about $900.[42]

The financial impact upon the above sample family's standard of living is indicated by Department of Labor statistics.[43] These figures show a breakdown in the average family budget as follows:

Food and Beverage	$1630
Housing	1370
Clothing	560
Medical	300
Transportation	540
Recreation, Personal, Gifts, Miscellaneous	720
Insurance	260
Taxes	620

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[41] Cf. Eagle, *Charges for Care and Maintenance in State Institutions for the Mentally Retarded*, 65 AMERICAN JOURNAL OF MENTAL DEFICIENCY, 199-207 (1960) as summarized in THE COMMITTEE ON RESIDENTIAL CARE OF NATIONAL ASSOCIATION FOR RETARDED CHILDREN, CHARGES FOR RESIDENTIAL CARE OF THE MENTALLY RETARDED (1963) at 15 and Fig. 14, Appendix.

[42] *Ibid.*

[43] U. S. DEP'T OF LABOR THE INTERIM CITY WORKER'S FAMILY BUDGET, MONTHLY LABOR REVIEW, REPORT NO. 2346 (1960) as cited in THE COMMITTEE ON RESIDENTIAL CARE OF THE NATIONAL ASSOCIATION FOR RETARDED CHILDREN, CHARGES FOR RESIDENTIAL CARE OF THE MENTALLY RETARDED (1963) Fig. 15, Appendix.

The payment to the state government of up to $900 per year for a substantial period of time would certainly impair some major aspect of that family's future development.

The states do not legislate in the same manner with reference to other afflictions. A 1958 study reveals drastic variations in the financial burdens then imposed by the states upon relatives of the mentally ill and mentally retarded as distinguished from relatives of persons with other disabling illnesses.[44] The following chart indicates that many states that charge for support of the mentally ill and retarded, do not charge at all for the blind, deaf, crippled, and the aged:[45]

Institutions for:	Number of states that: Charge	Do Not Charge
Mentally retarded	41	5
Mentally ill	29	4
Blind	4	31
Deaf	4	29
Crippled	3	28
Aged	2	27

. . .

II. THE CALIFORNIA STATUTE WHICH IMPOSES FINANCIAL LIABILITY UPON RELATIVES AS A CLASS FOR THE SUPPORT OF PATIENTS IN TAX-SUPPORTED STATE HOSPITALS CONTRAVENES THE EQUAL PROTECTION CLAUSE OF THE FOURTEENTH AMENDMENT.

Section 6650 of the California Welfare and Institutions Code provides that the husband, wife, father, mother or children of a mentally ill person or inebri-

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[44] See generally SMITH, A STUDY OF THE SYSTEM OF INSTITUTION CHARGES FOR THE MENTALLY RETARDED IN VIRGINIA AND THE NATION (1961).

[45] Id at Fig. 1, Appendix.

ate and the estates of such person shall be liable for the patient's care, support and maintenance in a state institution of which he is an inmate. Apart from the imposition of liability upon spouses, who have given adult consent to the assumption of responsibility for the other spouse, and the patient himself, the statute singles out those taxpayers who happen to be a relative of a person stricken with mental illness and, for the sole purpose of raising additional revenue, imposes a substantially greater financial liability to the state. The application of this statute to respondent violates the equal protection guarantee of the Fourteenth Amendment.[46]

Amicus does not deny that a state legislature must be able to classify in order to deal with particular subjects, situations or persons. Likewise, it appreciates that every effort at classification may not be subjected to valid constitutional challenge.

However, the mandate of the Equal Protection Clause requires, "the uniform treatment of persons standing in the same relation to the governmental action questioned. . . ." *Reynolds* v. *Sims*, 377 U.S. 533,

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[46] While California distinguishes between the mentally ill and the mentally retarded in its statutory scheme, relative contribution for the support and maintenance of the mentally retarded as well as the mentally ill will be affected by this decision, for a number of contribution statutes apply to both classes of patients; e.g., Connecticut, Illinois, Indiana, Michigan, New Jersey, Ohio, Oregon, Pennsylvania, Virginia, and Wisconsin. CONN. GEN. STAT. §§ 17-294, 295-98 (1963); ILL. STAT. ANN. ch. 91½ § 9-19 (1951); IND. ANN. STAT. §§ 22-401a-401d, 402, 405 (1935); MICH. STAT. ANN. § 14.811 (Supp. 1963); N.J. STAT. 30:4-66 (1953); OHIO REV. CODE ANN. §§ 5121.03, 5121.06 (Page Supp. 1960). ORE. REV. STAT. §§ 176.630, 427,055 (1959 Repl.); PA. STAT. ANN. tit. 1361 (Supp. 1960) tit. 71 § 1783; VA. CODE ANN. § 37-125.1 (Supp. 1964); WIS. STAT. ANN. § 46.10 (Supp. 1964).

565. The dominant consideration in judging the validity of a legislative classification is the relationship between the essential characteristics of the class singled out for special treatment and the objectives of the legislation. This Court has pointed out in *Walters* v. *City of St. Louis*, 347 U.S. 231, 237, that the classification must "rest on real and not feigned differences, . . . the distinction [must] have some relevance to the purpose for which the classification is made, and . . . the different treatments [must] not be so disparate, relative to the difference in classification, as to be wholly arbitrary. . . ." See also *Morey* v. *Doud*, 354 U.S. 457, 465. It must be determined, therefore, whether there is an arbitrary discrimination between those classes covered by the state law and those who are excluded. *McLaughlin* v. *State of Florida*, — U.S. —, 85 S. Ct. 283, 288.

Petitioner seems to imply at some stages of its argument that the objective of the statute is to benefit the patient or his relatives by reinforcing the familial obligation to aid a fellow member of the family in time of hardship (Brief, p. 22) while at another point it feels constrained to admit that the fundamental purpose of the legislation is to raise revenue (Brief, p. 6). It seems clear that the plain language of Section 6650 requires the second conclusion. The Supreme Court of California has recognized this to be the fact in *Department of Mental Hygiene* v. *McGilvery*, 50 Cal. 2d 742, 755, 329 P.2d 689, 695 (1958):

> The obvious purpose of the particular provisions of the statute here involved (§ 6650) is to minimize the cost to the state and its agencies in providing assistance to the needy and distressed, by exacting contributions from persons standing in close relationship to those assisted.

If the purpose of the instant statute is to raise revenue for public purposes, then it follows that the demands of the Fourteenth Amendment can be satisfied only if the statute singles out a class whose members are better able to supply that revenue than those who are excluded from the class at least where there is no other distinguishing characteristic that justifies the discriminatory treatment. It is common knowledge that the incidence of mental illness or retardation is in no way factually related to the wealth or poverty of the victim or of his relatives. *Cf.* Hollingshead and Redlich, *Social Class in Mental Illness* (1958). Some families with mentally ill members are rich; some are poor; some fall in the middle group. The classification based on family relationship simply bears no relationship to the statutory object of raising revenue.

Petitioner seeks to justify the imposition of the financial burden upon the ground of an underlying moral obligation. Amicus submits that it is unnecessary to determine whether such an obligation exists. Indeed, it may be questioned whether a court of law is a proper forum for the determination of such an issue. Amicus does contend, however, that even if it is assumed that a moral obligation exists upon a child to care for a parent, the existence of such an obligation confers no power in the state to justify the imposition of a financial liability of the kind imposed in this case upon a member of the family. The state certainly does not have the authority to determine that the extent of the obligation is the statewide average per capita cost of care of all mentally ill patients in all hospitals in the state. *Cf.* Cal. Welf. & Inst. Code § 6651.

If the statute is to be justified it must meet the ordinary tests of legislative classifications—a reasonable relationship between the object sought to be achieved and the distinguishing characteristics of the class upon whom the economic burden is to be placed. It is a mockery of the moral law to justify state taxation under the guise of implementing the child-parent relationship.

The inherently discriminatory nature of the instant classification reveals itself in other ways. Thus, as we have summarized above, there are irreconcilable variations in the amounts actually exacted from families of comparable income throughout those states which impose charges. It can hardly be argued that the nature and treatment of mental illness or mental retardation differ based on the geographical location of the patient. If the problem is common to all the states the explanation for the incomprehensible variations in the charges to be assessed may be found in arbitrary administration of these statutes. This again may stem from the fact that few state legislatures have supplied adequate guidelines for state collection agencies as to the determination of who shall be forced to pay and how much. The Welfare and Institutions Code of California, for example, does not provide any formula for determining relative ability to pay nor does it even list those elements of assets and liabilities which are to be considered relevant by the administrator in determining ability to pay. Section 6651 of that Code merely allows for adjustment of the payment "on satisfactory proof" that the estate or relatives are unable to pay the full per capita cost. Far from setting standards, the section

appears to place the burden of proof upon the relative or other party to establish inability to pay based on standards not supplied.

An additional indication of the unfair operation of statutes attempting to recoup the costs of public hospitals in the various states is the radically different treatment given to various kinds of major afflictions. As the chart set forth previously indicates the majority of the states exact some charge from patients and relatives of patients who are mentally ill and mentally retarded while a large number exact no charge from relatives of persons afflicted with blindness, deafness, and crippling illnesses. We see no rationale that would justify setting up a difference of financial liability on the relatives of those in public institutions for the mentally ill or mentally retarded where the state has determined that it is in the public interest not to exact such liability from relatives of persons with other serious and disabling afflictions.

The unfair burden upon relatives is heightened by facts indicating that the trend is for the states to expand and improve existing facilities for the mentally ill and mentally retarded. So urgent has the financial need become that the states have turned to the federal government for funds, and the federal government has responded. Clearly the problem of hospitalization for the mentally ill and mentally retarded has reached such a scale of magnitude as to preclude the imposition of the heavy burdens of support on any single group of citizens. On the contrary, modern society's increasingly recognized duty is to

assist those of its citizens confronted with catastrophic financial burdens by spreading the duty of support among all of its citizens. While it has always been understood that the family benefit from treatment of its sick members, we have progressed to such a point of social awareness that every citizen should be concerned when mental illness or retardation strikes at any other citizen and should recognize the benefits conferred upon himself and society when a fellow-citizen, though he be a stranger, receives needed care and rehabilitation at the hands of the state.

California, like others of its sister states, has erected and continues to maintain a complex and growing system of state hospitals for the mentally ill and for other afflictions. Many millions of dollars have been expended in the support and maintenance of these facilities. The construction and maintenance of these institutions are financed out of taxes collected from all taxpayers, whether or not these taxpayers chance to be related to persons afflicted with mental illness or mental retardation.

Any funds collected from the relatively small group of those made liable by the statute would tend to reduce proportionately the general taxpayer's liability. The substantial resources expended by California and other states in the construction, staffing and maintenance of these hospitals demonstrates an almost universal recognition of their importance to all citizens. Where a state has undertaken to employ general tax funds to create a complex of state hospitals, there appears no sound reason why the right of all the citizens of that state to enjoy the facilities on an

equal basis should be denied. *Cf. Griffin* v. *County School Bd. of Prince Edward County*, 377 U.S. 218.[47]

The projected increase in the costs of hospitalization which will be necessary to alleviate the presently existing deficiencies in the care of the mentally ill and the mentally retarded preclude a realistic assumption that any significant portion of future costs may be collected from families of the afflicted. At the present time no state collects more than 12 per cent of its institutional budget through this device and most collect less than 8 per cent. To sustain the decision of the Supreme Court of California would not pose a grave economic catastrophe for any state. Diminution of existing revenues from families would have an infinitesimal effect when spread over the general tax structure of a state.

On the other hand, the relief granted to each oppressed family would be significant. The results would

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[47] It is no answer to the patterns of discrimination evidenced in the statutes discussed that the injured relative may seek relief through legislative change. Such a contention is highly unrealistic. No matter how great the dimensions of the problems of mental illness and mental retardation become in the future, the patients and their families will always remain a small minority, relatively powerless to bring about the necessary legislative changes. Obviously, it is politically hazardous to propose an increase in general taxes in order to remove an unfair burden from a small percentage of voters even though the resulting increase in the share of each taxpayer will be relatively small. The unfortunate families who have financial burdens added to the emotional tragedy of mental illness and retardation can hardly hope for prompt legislative rescue.

To sustain the constitutionality of statutes such as the one now before the Court is to doom the relatives of the mentally ill and the mentally deficient to the systematic imposition of greater financial liabilities.

be seen in a higher standard of living and greater economic and educational opportunities for members of families now suffering under the weight of special revenue statutes such as that now before the Court.

CONCLUSION

For the foregoing reasons it is respectfully submitted that the judgment of the Court below should be affirmed.

Respectfully submitted,

A. KENNETH PYE
JOHN R. SCHMERTZ, JR.
506 E Street, N.W.
Washington, D. C. 20001

BERNARD D. FISCHMAN
330 Madison Avenue
New York, New York 10017